REVISION DATES: 03/30/2016; 12/21/2015; 11/13/2014; 09/30/2014; 04/07/2014

General Information

Within limitations, AHCCCS covers medically necessary medical and surgical services performed in offices, clinics, hospitals, homes, or other locations by licensed physicians, dentists, and mid-level practitioners.

Cosmetic surgery, experimental procedures, and unproven procedures are not covered.

Physicians and mid-level practitioners must bill for services on the CMS 1500 claim form. Services must be billed using appropriate CPT and HCPCS codes and procedure modifiers, if applicable. Dentists must bill for services on the ADA 2006 form using CDT-4 codes. The range of procedure codes that may be used by each provider type is listed in the provider type profile maintained by AHCCCS.

Providers should contact the Claims Customer Service Unit to determine if a procedure is covered by AHCCCS or if a specific code can be billed on a fee-for-service claim.

Phoenix area: (602) 417-7670 (Option 4)

All others: 1-800-794-6862 (In state)

1-800-523-0231, Ext. 7670 (Out of state)

The covered services, limitations, and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM) and Arizona Administrative Codes (A.A.C.) R9-22-201 et. seq. Please direct questions to the AHCCCS Office of Medical Policy, Analytics and Coding at (602) 417-4066.

The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS Web site at www.azahcccs.gov .

Correct Coding Initiative

AHCCCS follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on fee-for-service claims for the same provider, same recipient, and same date of service.

Correct coding means billing for procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code.

Some examples of **incorrect** coding include:

- Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Claims submitted to AHCCCS utilizing modifier 59 will be subject to Medical Review. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

Correction: to align with Medicare billing rule, **bilateral procedures** are to be billed on one line with the "50" modifier and the appropriate number of units. The rate valuation is 150% of the capped fee schedule.

Separate services during the post-operative period may be billed with modifier 58 or 78.

Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

CCI edits and audits are run on a prepayment basis. The CCI edit results are:

L140.1 - Invalid Coding Combination; Mutually Exclusive Code Paid (Deny)

L140.2 - Invalid Coding Combination; Component Previously Paid (Deny)

L140.3 - Invalid Coding Combination; Comprehensive Previously Paid (Deny)

L140.4 - Invalid Coding Combination; Multiple Component Codes (Deny)

L140.5 – Invalid Coding Combination; Ventilator Management with E/M Code (Deny)

L140.6 - Invalid Coding Combination; Discharge Management with E/M Code (Deny)

To meet CCI requirements, billers should follow these steps:

1. Determine if the code to be billed is a mutually exclusive code.

   Mutually exclusive procedures are those that cannot reasonably be performed in the same session (e.g., codes for “initial” and “subsequent” services).

   If a mutually exclusive code and its “partner” are billed on the same claim, the system will allow the code with the lowest capped fee. If the “partner” code has been paid, the system will deny the billed code.

2. Determine if the code to be billed is a component of a comprehensive code that also will be billed or that has been billed.

   The comprehensive code must be billed, if applicable. Claims for component codes that describe services distinct or separate from the services described by the comprehensive code may be reimbursed when billed with NCCI associated modifiers, if appropriate. CMS updates this modifier list quarterly. For current information please use the following link:

   https://www.cms.gov/medicare/coding/nationalcorrectcodinited/version_update_changes.html

3. Determine if the code to be billed is a comprehensive code.

If it is a comprehensive code and one of its components has been billed and paid, that claim for the component code must be voided before the comprehensive code can be billed.

Component codes cannot be billed if the comprehensive code is the most appropriate code.

Pregnancy Terminations

AHCCCS does not cover abortion counseling and pregnancy terminations unless:

- The pregnant recipient suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the recipient in danger of death unless the pregnancy is terminated, or
- The pregnancy is a result of rape or incest, or
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant recipient by:
    - Creating a serious physical or mental health problem for the pregnant recipient, or
    - Seriously impairing a bodily function of the pregnant recipient, or
    - Causing dysfunction of a bodily organ or part of the pregnant recipient, or
    - Exacerbating a health problem of the pregnant recipient, or
    - Preventing the pregnant recipient from obtaining treatment for a health problem.

All medically necessary abortions require prior authorization (PA) except in cases of medical emergency.

In the event of a medical emergency, all documentation of medical necessity must accompany the claim when submitted for reimbursement.

The request for PA must be accompanied by a completed Certificate of Medical Necessity for Pregnancy Termination (See the *AHCCCS Medical Policy Manual* (*AMPM*), Exhibit 410-1).

If the pregnancy is a result of rape or incest and the recipient is under 18 years of age, a parent or legal guardian must sign the Certificate of Necessity. The AHCCCS Utilization Management Care Management (UMCM) will review the request and the certification and may authorize the procedure if medically necessary.

Anesthesia Services

Anesthesia services (except epidurals) require the *continuous physical presence* of the anesthesiologist or certified registered nurse anesthetist (CRNA).

Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of MINUTES in Field 24G of the CMS 1500 claim form.

The begin and end time of the anesthesia administration must be entered on the claim on the line immediately below Field 24D/ ASA code.

The number of minutes billed must not exceed the period of time expressed by the begin and end time entered on the claim.

AHCCCS uses the limits and guidelines as established by ASA for base and time units. Every 15 minutes or any portion thereof is equal to one unit of time. (AHCCCS system will calculate units based on minutes billed) for most anesthesia procedures.

The AHCCCS system adds the base units for the ASA code to the number of base units (calculated from minutes billed) and multiplies the total by the established FFS rate to obtain the allowed amount.

Billing for labor and delivery

Providers should bill ASA code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes the repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)) for labor and delivery when epidural is used. Providers may bill for a maximum of 180 minutes (three hours).

If labor results in a Cesarean section, add-on code 01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) should be added. Providers should bill for the time of the Cesarean section portion of the service only. A base of 5 units is added for the ASA code 01967, and a base of 3 units is added for 01968.

For all other labor and delivery, ASA codes 01960 (Anesthesia for vaginal delivery only) and code 01961 (Anesthesia for Cesarean delivery only) should be used.

Providers who bill other CPT codes for additional procedures performed during anesthesia administration must use the units field to indicate the number of times the procedure was performed.

Providers should not include the Basic Unit Value listed in the ASA Manual as part of the units billed.

For example:

A provider who bills 36556 (Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) should bill one unit.
Billing the Basic Unit Value of four would indicate placement of four catheters.

Reimbursement is based on capped fee schedule.

Anesthesia Medical Direction

The following modifiers are to be used for anesthesia medical direction:

QK- Medical direction of two, three or four concurrent anesthesia procedures
QX- Anesthesia, CRNA medically directed
QY- Medical direction of one CRNA by anesthesiologist

Reimbursement of each provider will be at 50% of the AHCCCS capped fee schedule

Two separate claims must be filed for medically directed anesthesia procedures- one for the anesthesiologist and one for the CRNA. Medical direction can occur in several different scenarios. When billing for the anesthesia services, please refer to the following examples for appropriate modifier usage:

- An anesthesiologist is medically directing one CRNA. The anesthesiologist should bill with the QY modifier and the CRNA should bill with the QX modifier.
- An anesthesiologist is medically directing two, three or four CRNA's. The anesthesiologist should bill with the QK modifier and the CRNA should bill with the QX modifier.

The following anesthesia services are not covered:

- 00938 (Insertion of penile prosthesis)
- Qualifying circumstances codes
- Physical status codes

Dental Services

In accordance with Arizona Administrative Code (A.A.C.) R9-22-207, AHCCCS covers limited dental services for adult recipients (age 21 years age and older).

For adult recipients (age 21 years old and older) AHCCCS covers medical and surgical services furnished by a dentist *only to the extent that such services*:

- *May be performed under state law by either a physician or by a dentist* and
- *the services would be considered physician services if furnished by a physician*.

Services furnished by dentists must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw.

A. Covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.

B. The services do NOT include: dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures.

Diagnosis and treatment of TMJ is not covered except for reduction due to trauma.

AHCCCS covers limited dental services for covered transplantation and for covered radiation treatment for cancer of the jaw, neck, or head.

Prophylactic extraction of teeth in preparation for radiation treatment for cancer of the jaw, neck or head is covered.

As a prerequisite to covered transplantation, AHCCCS covers dental services necessary for the elimination of oral infections and the treatment of oral disease, which include:

- Dental cleanings
- Treatment of periodontal disease
- Medically necessary extractions, and
- Provision of simple restorations (limited to silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns

AHCCCS covers these services only after a transplant evaluation determines that the recipient is an appropriate candidate for covered organ or tissue transplantation.

Dental Services for Recipients under Age 21: EPSDT Services

AHCCCS covers comprehensive health care for recipients under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT covers all medically necessary services described in federal law 42 USC 1396d to treat or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening, whether or not the service is described in the State Plan.

Covered EPSDT dental services for recipients under age 21 and KidsCare recipients include, but are not limited to:

- Screening and preventive services specified in the periodicity schedule
- Emergency dental services
- All medically necessary therapeutic dental services

Prior authorization requirements for dental services

PA is not required for emergency dental services, preventive or for medically necessary therapeutic dental services for EPSDT and KidsCare recipients.

Dental surgery services for EPSDT and KidsCare recipients require PA.

Pre-transplant dental services that are medically necessary in order for the recipient to receive the major organ or tissue transplant require prior authorization from the AHCCCS transplant case manager.

Billing requirements

Dentists must bill on the ADA 2012 claim form using CDT-4 codes.

Only oral surgeons registered as Provider Type 07 (Dentists) may use CPT Evaluation and Management (E/M) codes on the CMS 1500 claim form to bill AHCCCS for office visits.
Dentists who are not oral surgeons must use one of the following codes to bill for office visits and evaluation services:

D0120 - Periodic oral exam
D0140 - Limited oral evaluation -- problem focused
D0150 - Comprehensive oral evaluation
D0160 - Detailed and extensive oral exam -- problem focused
D9430 - Office visit for observation (during regularly scheduled hours) – no other services performed
D9440 - Office visit -- after regularly scheduled hours

Dentists may use appropriate E/M codes for hospital consultation, emergency room services, and hospital visits.

Effective 4/1/2014 **AMPM Policy 431** EPSDT Oral Health Care **advises that the physician, physician's assistant or nurse practitioner must perform an oral health screening as part of the EPSDT physical examination.**

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for recipients who are at least 6 months of age, with at least 1 tooth eruption. Additional applications occurring every 6 months during an EPSDT visit, up until the recipient's 2nd birthday, may be reimbursed according to the AHCCCS fee schedule. Refer to AMPM Policy 431 for further details regarding fluoride varnish application and the AHCCCS recommended training information.

PCPs and attending physicians must refer EPSDT recipients to a dentist for appropriate services based on the needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 431-1). Evidence of the referral must be documented on the ESPDT Tracking Form and in the recipient's medical record.

Recipients must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS EPSDT Periodicity Schedule. The physician may refer EPSDT recipients for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/of treatment by a dental professional. In addition to physician referrals, EPSDT recipients are allowed self-referral to an AHCCCS registered dentist.

Refer to AMPM Policy 431 for covered services, provider requirements, informed consents and treatment plans.

Discharge Management

Physicians and mid-level practitioners who bill Evaluation and Management (E/M) codes 99238 and 99239 for discharge management should not bill any other evaluation and management code for the same date when submitting claims to AHCCCS.

The E/M codes for hospital discharge day management are used to report all services provided on the date of discharge, including final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

If a provider submits a claim for discharge management and another E/M code for the same date, the E/M code will be paid, but the discharge management code will be denied.

EPSDT Program Services

AHCCCS covers comprehensive health care for recipients under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

EPSDT also covers all medically necessary services to treat or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the service is covered under the State Plan.

KidsCare (Title XXI) recipients are eligible for nearly the same services as ESPDT recipients eligible under Title XIX. However, KidsCare recipients are not eligible for licensed midwife services and home births.

EPSDT screening services are to be provided in compliance with AHCCCS medical policy including the periodicity schedule which meet reasonable standards of medical practice and specified screening services at each stage of a child's life. **Refer to AMPM Policy 430 for comprehensive changes effective 4/1/2014 for EPSDT** and Exhibit 430-1 for the updated EPSDT Periodicity Schedule.

The EPSDT screening requirements are:

- Comprehensive health, nutritional and developmental history
- Comprehensive unclothed physical examination
- Screening for immunizations appropriate to age and health history.
- Laboratory tests
- Health education
- Vision, speech and hearing assessment

- Age appropriate dental screening
- Behavioral health services
- Oral health screening
- Tuberculin skin testing

Effective 4/1/2014 EPSDT/Well Child visits are all-inclusive visits. The payment for the EPSDT is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibilt 430-1). Refer to AMPM Policy 430 for exceptions to the all-inclusive visit global payment rate.

Claims must be submitted on CMS 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventative medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in AMPM Policy 430. No additional reimbursement is allowed.

Providers must use an EP modifier to designate all services related to the EPSDT well child check-up, including routine vision and hearing screenings.

Providers must be registered as **Vaccines for Children (VFC) Program** providers and VFC vaccines must be used. Under the federal VFC program, providers are paid a capped fee for administration of vaccines to recipients 18 years old and younger.

For VFC claims incurred prior to 1/1/2013**,** Providers must bill the appropriate CPT code for the immunization with the "SL" (State supplied vaccine) modifier that identifies the immunization as part of the VFC program.

Providers must *not* use the immunization administration CPT codes 90471, 90472, 90473, and 90474 when billing under the VFC program.

Because the vaccine is made available to providers free of charge, providers must not bill for the vaccine itself.

For VFC services incurred on/after 1/1/2013**,** Section 1202 of the Patient Protection and Affordable Care Act (ACA) requires AHCCCS to modify how providers submit claims for vaccine administration services.

Beginning with dates of service 1/1/2013, AHCCCS will require all providers to submit two CPT codes for VFC program services, both billed with modifier SL:

- One code will identify the vaccine administrative service described by codes 90460, 90461, 90471, 90472, 90473 and 90474 *and billed with SL modifier*
- The second code, with the SL modifier, will identify the actual vaccine administered

24. A	B	C	D	E	F
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges
1/1/13-1/1/13	11		90460 **SL**	1	$xx.xx
1/1/13-1/1/13	11		90700-SL	1	0.00

Follow CPT guidelines for the appropriate administration code usage.

No payment will be made for the vaccine provided through the VFC program. Payment will be made for the administration at the rates in effect for that service at the time the VFC immunization was administered.

For a list of vaccines covered under the VFC Program refer to Arizona Department of Health Services (ADHS) website www.adhs.gov for the chart titled "VFC Program Vaccine Availability Form".

REMINDER: these billing instructions are ONLY for vaccines through the VFC Program administered to recipients 18 years or younger.

Family Planning Services

Family planning services are provided to eligible recipients who voluntarily choose to delay or prevent pregnancy and include covered medical, surgical, pharmacological and laboratory benefits.

Family planning services include the provision of accurate information and counseling to allow eligible recipients to make informed decisions about the specific family planning methods available.

Covered services include:

- Contraceptive counseling, medications, supplies and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams, and suppositories
- Voluntary sterilization (male and female)
- Natural family planning education or referral to qualified health professionals

Limitations and exclusions:

- Services for the diagnosis or treatment of infertility are not covered.
- Abortion counseling is not covered.
- Pregnancy terminations are not covered unless 1) the pregnancy termination is necessary to protect the life of the mother, 2) the pregnancy termination is medically necessary to prevent a serious physical or mental health problem for the pregnant mother, or 3) the pregnancy is the result of rape or incest. (See Page 10-4):
- Sterilization services are not covered for Federal Emergency Services (FES) recipients, and claims for sterilization services for ESP recipients will be denied.

AHCCCS requires a completed Federal Consent Form to be submitted with claims for all voluntary sterilization procedures.

Federal consent requirements for voluntary sterilization are:

- The recipient to be at least 21 years of age at the time consent is signed.
- The recipient to be mentally competent.
- Consent to be voluntary and obtained without duress.

- Thirty days, but not more than 180 days, to have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- At least 72 hours to have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery.
- The informed consent to have been given at least 30 days before the *expected* date of delivery in the case of premature delivery.
- The person securing the informed consent and the physician performing the sterilization procedure to sign and date the consent form.
- A copy of the signed Federal Consent Form to be submitted by each provider involved with the hospitalization and/or the sterilization procedure.
- The sterilization consent may not be obtained when an eligible recipient:
  - Is in labor or childbirth.
  - Is seeking to obtain or obtaining an abortion.
  - Is under the influence of alcohol or other substances that affect that recipient's state of awareness.

Providers must bill for IUDs on the CMS 1500 claim form using the following codes:

J7300	Intrauterine copper contraceptive (Paraguard)
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)
S4989	Contraceptive intrauterine device (e.g. progestacert IUD), including implants and supplies

Prior to 1/1/2013 providers must bill for Depo-provera injections on the CMS 1500 claim form using HCPCS code J1055 - Depo-provera (150 mg). Effective 1/1/2013 the Depo-provera injections should bill billed with HCPCS code J1050 (1 mg).

Norplant insertion is not an AHCCCS-covered service because the manufacturer, Wyeth, is no longer distributing Norplant in the United States.

Essure insertion must be billed on a CMS 1500 claim form using CPT code 58565.

Foot and Ankle Care

In accordance with Arizona Administrative Code A.A.C. R9-22-21 AHCCCS covers medically necessary foot and ankle care, including reconstructive surgeries, when ordered by a recipient's primary care provider, attending physician or practitioner, within certain limits, for eligible recipients.

Foot and ankle services are not covered for adults (age 21 and older) when provided by a podiatrist or podiatric surgeon.

Routine foot care is designated as those services performed in the absence of localized illness, injury or symptoms involving the foot. Routine foot care is considered medically necessary in very limited circumstances as described below. These services include:

- The cutting or removal of corns or calluses
- The trimming of nails (including mycotic nails)
- Other hygienic and preventive maintenance care in the realm of self-care (such as cleaning and soaking the fee, and the use of skin creams to maintain skin tone or both ambulatory and bedfast patients).

Coverage includes medically necessary foot and ankle care such as wound care and treatment of pressure ulcers.

Foot and ankle care also includes fracture care, reconstructive surgeries, and limited bunionectomy services.

Routine foot care is considered medically necessary when the recipient has a systemic disease of sufficient severity that performance of foot care procedures by a nonprofessional person would be hazardous.

Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include but are not limited to:

- Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitis obliterans)
- Chronic thrombophlebitis
- Diabetes mellitus
- Peripheral neuropathies involving the feet
- Recipient receiving chemotherapy
- Pernicious anemia
- Hereditary disorder, i.e. hereditary sensory radicular neuropathy, Fabry's disease

- Hansen's disease or neurosyphilis
- Malabsorption syndrome
- Multiple sclerosis
- Traumatic injury
- Uremia (chronic renal disease)
- Anticoagulant therapy

Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered in the following circumstances:

- A systemic condition, and
- Clinical evidence of mycosis of the toenail, and
- Compelling medical evidence documenting the recipient either:
    - Has a marked limitation of ambulation due to the mycosis which requires active treatment of the foot, or
    - In the case of a non-ambulatory recipient, has a condition that is likely to result in significant medical complications in the absence of such treatment.

Foot and Ankle Care Limitations

Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to early and periodic screening, diagnosis and treatment (EPSDT) recipients). A "contract year" is defined as October 1-September 30.

Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to EPSDT recipients).

Neither general diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency or incapacitation injuries or illnesses such as rheumatoid arthritis, CVA (stroke) or fractured hip are diagnosis under which routine foot care is covered.

Bunionectomy is covered only when the bunion is present with overlying skin ulceration, or neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Foot and Ankle Care Prior Authorization requirements

All foot and ankle services not covered by Medicare require Prior Authorization.

Refer to AMPM Chapter 310-U for further information.

Health Care Acquired Conditions & Provider Preventable Conditions

Section 2702 of the Affordable Care Act (ACA) prohibits Medicaid programs from reimbursing certain providers for services resulting from a "provider preventable condition" (PPC). PPCs are comprised of two categories:

1) health care acquired conditions (HCACs), and
2) other provider preventable conditions (PPCs).

Beginning July 1, 2012, AHCCCS will implement policies that conform to the federal requirements regarding HCACs and PPCs.

HCAC

For Medicaid, HCACs are defined as conditions identified by Medicare as Hospital Acquired Conditions (HACs) occurring in the inpatient hospital setting which includes any of the following:

- Retained foreign object following surgical procedures;
- Air embolism;
- Blood incompatibility;
- Stage III and IV pressure ulcers;
- Injuries resulting from falls and trauma;
- Catheter associated urinary tract infections;
- Vascular catheter associated infections;
- Manifestations of poor glycemic control;
- Mediastinitis following coronary artery bypass graft (CABG) procedures;
- Surgical site infections following orthopedic surgery procedures involving spinal column fusion or re-fusion, arthrodeses of the shoulder or elbow, or other procedures on the shoulder or elbow;
- Surgical site infections following bariatric surgery procedures;
- Deep vein thrombosis or pulmonary embolism following total hip or knee procedures, except in pediatric or obstetrical patients.

Inpatient hospitals will not be paid any incremental or additional fees for treating an HCAC that is not present on admission to the facility, regardless of the cause of the HCAC. No reduction in payments will be assessed if the HCAC is present on admission or if the identification of the HCAC would not otherwise result in additional payments to

the provider. The amount not paid to the facility is limited to the additional payments that would otherwise be paid for the treatment of and related to the HCAC.

For Medicaid, HCACs are defined as conditions identified by Medicare as Hospital Acquired Conditions (HACs) occurring in the inpatient hospital setting which includes any of the following diagnosis codes E870-E876.9

PPC

Unlike HCACs, PPCs are not confined to conditions occurring in the inpatient hospital setting, but may occur in either the inpatient or outpatient setting. In this case, "outpatient" is not limited to hospital outpatient departments, but may include other outpatient settings, such as a clinic, Ambulatory Surgical Center (ASC), Federally Qualified Health Center, or physician's office.

State Medicaid programs have significant flexibility to define conditions they consider to be PPCs, but at a minimum must identify any of the following three occurrences as an PPC:

- Wrong surgical or other invasive procedure performed on the patient;
- Surgical or other invasive procedure performed on the wrong body part; or
- Surgical or other invasive procedure performed on the wrong patient.

At this time AHCCCS will adopt the minimum list of procedures above as PPCs for purposes of implementing Section 2702 of the ACA. When a PPC occurs in either the inpatient or outpatient setting, payments for the services resulting in the PPC will not be made to either the facility in which the PPC occurred or to the professionals involved in performing the procedure that resulted in the PPC.

Reporting PPCs

Under the federal rule implementing Section 2702, providers must affirmatively report the occurrence of any PPC in a Medicaid recipient, regardless of whether the provider has submitted a claim for payment for the services that resulted in the PPC. Providers should report these occurrences through the use of the appropriate codes on the UB04 claim form in the case of a hospital or the CMS 1500 claim form for professionals.

AHCCCS will utilize the following modifiers to define conditions they consider to be PPCs:

PA: Surgery wrong body part
PB: Surgery wrong patient
PC: Wrong surgery on patient

Health Risk Assessment and Screening Tests

For adults (age 21 years old and older) AHCCCS covers health risk assessment and screening tests pursuant to A.A.C. R9-22-205 provided by a physician, primary care provider or other licensed practitioner within the scope of his/ her practice under State law for all recipients.

These services include appropriate clinical heath risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status.

For adults (age 21 years and older) well exams are not covered. Well exams are physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination. Effective with date of service 10/1/2013 adult (age 21 years and older) well visits and well exam coverage will be re-instated.

Certain preventive services such as immunizations, PAP smears, colonoscopies, and mammograms are covered for adults (age 21 and older). (for adult immunizations, refer to AMPM Policy 310-M)

Health risk assessment and screening tests are also covered for recipients (under age 21) through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and KidsCare Program.

Preventive health risk assessment and screening tests services for non-hospitalized adults (age 21 and older) include, but are not limited to:

- Hypertension screening (annually)
- Cholesterol screening (once; additional tests based on history)
- Mammography (annually after age 40; recommended annually for younger females who are at high risk due to immediate family history)
- Cervical cytology (annually for a sexually active woman; after three successive normal exams the test may be less frequent)
- Colon cancer screening (digital rectal exam and stool blood test, annually after age 50 as well as baseline colonoscopy after age 50)
- Sexually transmitted disease screening (at least once during pregnancy; other, based on history)

- Tuberculosis screening (once; additional testing based on history or for AHCCCS recipients residing in a facility, as necessary per health care institution licensing requirements)
- Immunizations (refer to AMPM 310-M Immunizations for details)
- HIV-screening
- Prostate screening (annually after age 50; recommended annually for males 40 and older who are at high risk due to immediate family history)
- Physical examinations, periodic health examinations or assessments, diagnostic work ups or health protection packages designed to: provide early detection of disease; detect the presence of injury or disease; establish a treatment plan; evaluate the results or progress of treatment plan or the disease; or to establish the presence and characteristics of a physical disability which may be the result of disease or injury.

Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Physical examinations performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

- Qualification for insurance
- Pre-employment physical examination
- Qualification for sports or physical exercise activities (does not apply to EPSDT recipients)
- Pilots examinations (FAA)
- Disability certification to establish any kind of periodic payments
- Evaluation for establishing third party liability
- In accordance with A.A.C. R9-22-205 preventive examination in the absence of any known disease or symptom for recipients 21 years of age or older

Prior Authorization requirements**:**

Prior Authorization for medically necessary health risk assessment and screening services is not required.

Hysterectomy Services

AHCCCS covers medically necessary hysterectomy services.

AHCCCS does not cover a hysterectomy service if it is performed solely to render the individual permanently incapable of reproducing.

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except for treatment of carcinoma and management of life-threatening hemorrhage, has been preceded by a trial of therapy (medical or surgical) which was proven unsatisfactory.

Hysterectomy services may be considered medically necessary without a trial of therapy in the following cases:

- Invasive carcinoma of the cervix
- Ovarian carcinoma
- Endometrial carcinoma
- Carcinoma of the fallopian tube
- Malignant gestational trophoblastic disease
- Life-threatening uterine hemorrhage, uncontrolled by conservative therapy
- Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruptio

Hysterectomy services require prior authorization. In a life-threatening emergency, PA is not required, but the physician must certify in writing that an emergency existed.

All claims for hysterectomy services are subject to medical review.

A hysterectomy consent form (See AMPM Chapter 800 Exhibit 820-1), or a hospital consent form that contains the same information as the Exh. 820-1 hysterectomy consent form, must be submitted with the claims. The consent form must state that the patient will be permanently incapable of having children.

The consent form must be signed by the recipient, the physician who performs the hysterectomy, the person who obtains the recipient's consent and, if applicable, an interpreter.

Licensed Midwife Services

A licensed midwife is an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to ARS §36-751 and AAC Title 9, Chapter 16, Article 1.

This provider type does not include certified nurse midwives licensed by the Arizona Board of Nursing as nurse practitioners or physician assistants licensed by the Arizona Board of Medical Examiners.

Labor and delivery services provided by licensed midwives generally are provided in the recipient's home. Licensed midwife services cannot be provided to AHCCCS recipients in a hospital, free-standing birthing center, or other licensed health care institution.

Licensed midwives must obtain prior authorization from AHCCCS UM/CM. Documentation certifying risk status of the recipient's pregnancy must be submitted prior to providing licensed midwife services.

Licensed midwife services may be provided only to pregnant AHCCCS recipients for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated.

- The age of the recipient must be a consideration in the risk status evaluation.
- Risk status must be determined at the time of the first visit and each trimester thereafter.
- Recipients initially determined to have a high-risk pregnancy or recipients whose physical condition changes to high risk during the course of the pregnancy must immediately be referred to an AHCCCS-registered physician or practitioner.

Upon delivery of the newborn, the licensed midwife is responsible for conducting the newborn examination and for referring the mother and newborn to a physician for follow-up care of any assessed problematic conditions.

The licensed midwife also must notify the AHCCCS Administration's Newborn Reporting Line no later than three days after the birth in order to enroll the newborn with a health plan.

Licensed midwives must bill for delivery using CPT-4 code 59400 - Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care. Prenatal and postpartum care is bundled into one service, and all services related to the care of the pregnant woman are included in this reimbursement rate. Reimbursement is the lesser of billed charges or the AHCCCS capped fee.

If complications arise during the pregnancy and the woman must be referred to a physician, the licensed midwife may bill for prenatal care only using CPT code 99212 - Office or other outpatient visit for the evaluation and management of an established patient. Each visit date should be billed on a separate line of the CMS 1500 claim form.

Nutritionist Services

Nutritionists can bill for services covered under codes B4034-B9999, G0270, G0271, S9470, 97802-97804.

Nutritional evaluations are covered under the following circumstances:

- Hospice services
  Dietary services which include a nutritional evaluation and dietary counseling when necessary

- Total Parenteral Nutrition (TPN)
  AHCCCS follows Medicare guidelines for the provision of TPN services. TPN is covered for recipients over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

  AHCCCS covers TPN for recipients receiving EPSDT and KidsCare recipients when medically necessary and not necessarily the sole source of nutrition. Refer to Chapter 400 of the AHCCCS Medical Policy Manual for complete information.

- Transplant Services
  Nutritional assessments. Refer to Chapter 310 of the AHCCCS Medical Policy Manual for complete information.

REMINDER: Diabetic Education services are <u>NOT</u> an AHCCCS covered service.

Obstetrical Services

Refer to AMPM Chapter 400 Medical Policy for Maternal and Child Health for federal and state regulatory requirements. AMPM Exhibit 410-3 pages 1-5 provides Initial Screening and Antepartum Risk Assessment Tools that can be used as a guide. AMPM Chapter 410-D 1. states "Physicians and practitioners must follow the American College of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment."

The AHCCCS global obstetrical (OB) package includes ***all*** OB visits prior to the delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital for delivery.

Evaluation and management (E/M) codes for office and/or hospital visits may not be unbundled from the global OB code and billed separately. Claims for these services will be denied when billed in addition to the global OB code.

The global OB package includes:

1 visit/month for the first 28 weeks gestation	7 visits
Biweekly visits to 36 weeks gestation	4 visits
1 visit/week up to delivery date (39 weeks gestation)	3+ visits

All inpatient visits including admit and discharge from the hospital

All postpartum visits for 60 days following discharge from the hospital, including family planning

Global obstetric codes include all antepartum and postpartum services and therefore encompass all services rendered to the mother.

Medical complications of pregnancy *may* require additional resources outside the global OB care package as outline above and may be reported separately. The medical complication(s) must be present as supported by the medical documentation, including but not limited to, maternal medical history & physical, lab results and imaging reports.

The global OB package does not include:

Consultation by a specialist other than OB/G when referred by the treating physician or practitioner;

Consultation by an OB/G specialist physician not affiliated with the treating physician or practitioner;

Other services as supported by medical necessity with documentation.

Providers *must* bill the global OB code if the recipient is seen five or more times prior to delivery.

Physicians, practitioners and certified nurse practitioners in midwifery (CNMs) may not bill the global OB package if the recipient has been seen for less than 5 visits prior to delivery.

If a CNM refers a recipient to a *non-affiliated* physician for on-going OB care, that physician may bill for the visits plus the delivery, unless the requirements for billing the global OB code are met.

The CNM who referred the recipient may bill for the visits that occurred prior to referring the patient to the *non-affiliated* physician for on-going OB care.

The CNM may not bill for the delivery or global OB code if the delivery is billed by another provider.

Billing for other than total care

- A provider may not bill the global OB code or codes for postpartum care if the delivery is the only service provided.
- A provider who performs a *delivery and subsequent postpartum care only* should consult the CPT code book for the appropriate CPT codes.
- A provider billing for *postpartum care only* should use CPT code 59430.
- A provider billing for *antepartum care only* should use CPT codes 59425 (4 - 6 visits and services) or 59426 (7 or more visits and services).
- For 1 - 3 antepartum care visits, a provider should use the appropriate E/M Codes.

Global obstetric codes include all antepartum and postpartum services and therefore encompass all services rendered to the mother, including instances of multiple gestations.

The global code includes delivery services for one baby.

When billing delivery services for twin births, providers should bill only one global obstetric care code. Delivery of the second baby should be billed using the appropriate code for delivery only.

Ordering Provider

Effective 1/1/2012 for FFS the following services require the submission of an ordering provider:

- Laboratory
- Radiology
- Medical and Surgical Supplies
- Respiratory DME
- Enteral and Parenteral Therapy
- Durable Medical Equipment
- Drugs (J-Codes)
- Temporary K and Q codes
- Orthotics
- Prosthetics
- Vision codes (V-codes)
- 97001-97546

Ordering providers must be M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

Claims submitted without the ordering provider listed will be denied.

Pathology and Laboratory Services

Diagnostic testing and screening are covered services.

Pass-through billing by which the physician pays the laboratory for tests and then bills AHCCCS for the lab services is not allowed.

AHCCCS follows Medicare guidelines that specify which codes may be billed using the professional (26) and/or technical lab component (TC) modifiers.

When the procedure code for the test is for the technical component only or the professional component only, the procedure should be billed without a modifier.

Laboratory tests with automated results do not have a professional component, and claims for the professional component should not be billed for those laboratory services.

Laboratory services for hospitalized recipients must be included on the UB-04 inpatient claim. These services may not be unbundled and billed as -TC separately from the inpatient claim.

In accordance with Medicare guidelines, physicians may bill only a limited number of CPT codes for pathology services performed in a hospital setting.

- AHCCCS follows Medicare guidelines and will only pay physicians and other individual practitioners for the medical interpretation of a pathology test performed at a hospital.

- AHCCCS does not reimburse physicians for the technical portion of tests performed at hospitals or for any indirect costs, such as supervising the laboratory.
    - The hospital is reimbursed for the technical component of the test performed in its facility.
    - The hospital is also responsible for compensating employees that may be supervising the lab.

Radiology and Medical Imaging Services

Diagnostic testing, imaging and MRI are covered services.

Positron emission tomography (PET) scans are covered only at PET imaging centers with PET scanners that have been approved by the FDA.

No PA is required for medically necessary radiology and medical imaging services.

Radiology services provided to hospitalized recipients must be included on the UB-04 claim.

- These services may not be unbundled and billed separately from the inpatient claim.
- The professional services of a radiologist may be billed separately with a 26 modifier.

Rehabilitation Therapies (Occupational, Physical and Speech)

AHCCCS covers physical, occupational, speech and respiratory therapy services that are ordered by a primary care provider (PCP), or attending physician for FFS recipients, approved by DFSM UM/CM and provided by, or under the direct supervision of a licensed therapist. Refer to AMPM Chapter 300 Section 310-X and AMPM Chapter 1200 for additional information regarding ALTCS covered rehabilitation services.

Occupational Therapy

Occupational Therapy services are medically ordered treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost, or reduced by illness or injury. OT is intended to improve the recipient's ability to perform those tasks required for independent functioning.

Occupational Therapists must be licensed by the Arizona Board of Occupational Therapy Examiners, or governing Board of the State where the therapist practices or a certified OT assistant (under the supervision of the occupational therapist) licensed by the Arizona Board of Occupational Therapy Examiners.

Outpatient OT services are covered only for EPSDT, KidsCare and ALTCS recipients.

AHCCCS covers medically necessary OT services provided to all recipients who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the recipient's PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Therapy services may include, but are not limited to:

Cognitive training
Exercise modalities
Hand dexterity
Hydrotherapy
Joint protection
Manual exercise
Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
Perceptual motor testing and training
Reality orientation
Restoration of activities of daily living
Sensory reeducation, and
Work simplification and/or energy conservation.

Physical Therapy

Physical therapy (PT) is an AHCCCS covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function.

Physical Therapists must be licensed by the Arizona Board of Physical Therapy or the governing Board of the State where the therapist practices. A Physical Therapy Assistant (under the supervision of the PT according to A.A.C. 24, Article 3) must be certified by the Arizona Physical Therapy Board of Examiners. Out of state physical therapists providing services to AHCCCS recipients outside the State of Arizona must meet applicable State and/or Federal requirements.

AHCCCS covers medically necessary PT services for recipients in an inpatient or outpatient setting, when services are ordered by the recipient's PCP/Attending physician as follows:

1. Inpatient PT services are covered for all recipients who are receiving inpatient care at a hospital (or a nursing facility)

2. Outpatient PT services are covered for EPSDT and KidsCare recipients when medically necessary

Outpatient settings include, but are not limited to: physical therapy clinics, outpatient hospital units, FQHCS, home health settings and physician offices.

An outpatient PT visit is defined as service(s):

- identified by CPT codes 97001-97546,
- received in one day
- billed on form types 1500 and UB-04
- by any provider type except 13 – Occupational Therapist, or 22 – Nursing Home; and
- billed with any place of service except 31 – Nursing Home, 32 – Nursing facility, or 33 – Custodial facility.

Service limits will be applied to outpatient physical therapy CPT codes 97001 – 97546 for AHCCCS enrolled recipients as follows:

- Services occurring on the same day with either the same or different providers will count as a single visit.
- Multiple services provided on the same day will be counted as a single visit.

In accordance with A.A.C. R9-22-215, outpatient PT services are covered for adult recipients, 21 years of age and older (ACUTE and ALTCS), as follows:

A. AHCCCS recipients who are not Medicare eligible are limited to 15 outpatient visits per contract year regardless of whether or not the recipient changes Contractors. (contract year is defined as October 1-September 30).

B. For AHCCCS recipients who are also Medicare recipients, refer to AMPM Chapter 300, Exhibit 300-3C and the ACOM Manual Policies 201 and 202 regarding Medicare cost sharing and the outpatient physical therapy limit.

Dual Eligible refers to a recipient with income above 100% FPL who is Medicare and AHCCCS eligible (also known as Medicare Primary, non-QMB dual). The recipient does not qualify for the Federal QMB program. The health plan is responsible for the Medicare cost sharing amount (Medicare's deductible, copay and coinsurance) up to 15 PT visits.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan will pay the Medicare cost sharing up to the 15 visit limit per contract year.

As part of their Medicare benefit, recipients may opt to receive service up to Medicare maximum dollar amount; however the Medicare cost sharing for any visits beyond the 15 visit limit allowed by AHCCCS are the recipient's responsibility.

Should the recipient exhaust their Medicare dollar maximum amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the health plan.

QMB Dual refers to a recipient with income not exceeding 100% FPL who qualifies for Medicare under the Federal QMB program and is enrolled in Medicaid. The health plan is responsible for the Medicare cost sharing amount (Medicare deductible and coinsurance) up to the Medicare maximum dollar amount.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.

Should the recipient exhaust their Medicare maximum dollar amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the health plan.

Physical therapy prescribed only as a maintenance regimen is excluded.

Effective 1/1/2014 outpatient physical therapy for adults (age 21 years and older) is limited to the following:

A. 15 visits per contract year to restore a particular skill or function the recipient previously had but lost due to injury or disease and maintain that function once restored; and

B. 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

Refer to AMPM Exhibit 300-3 C for more detail regarding Medicaid only recipients, QMB Dual and Medicare Primary (non-QMB Dual).

Authorized physical therapy treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the recipient's treatment
2. The administration, evaluation and modification of treatment methodologies and instruction, and
3. The provision of instruction or education, consultation and other advisory services.

Speech Therapy

Speech therapy is the medically ordered provision of diagnostic and treatment services that include evaluation, diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

A qualified Speech-Language Pathologist (SLP) must be licensed by the Arizona Department of Health Services (ADHS) or a Speech-Language Pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified Speech-Language Pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed.

A qualified Speech-Language Pathology Assistant (SLPA) must be licensed by the Arizona Department of Health Services (ADHS). The SLPA must be identified as the servicing provider and bill for services under his/her individual NPI number. (A group ID number can be utilized to direct payment). SPLA's may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.

AHCCCS covers medically necessary speech therapy services provided to all recipients who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the recipient's PCP or attending physician for FFS recipients.

Speech therapy provided on an outpatient basis is covered only for recipients receiving EPSDT services, KidsCare and ALTCS recipients.

Speech therapy by qualified professionals may include the services listed below:

Articulation training	Language treatment
Auditory training	Lip reading
Non-oral language training	Cognitive training
Oral-motor development	Esophageal speech training
Swallowing training	Fluency training

Rehabilitative Therapy prior authorization requirements

The following written documentation must be received by AHCCCS/DFSM UM/CM prior to the issuance of a PA number:

- Nature, date, extent of injury/illness and initial therapy evaluation
- Treatment plan, including specific services/modalities of each therapy, and
- Expected duration and outcome of each therapy provided.

Upon concurrent review and/or receipt of the above documentation, which substantiates AHCCCS rehabilitation requirements, authorization will be given.

Progress notes may be requested by the AHCCCS/DFSM/PA Unit every 10 days, as evidence of recipient progress for continued authorization (when there is no concurrent review).

Outpatient rehabilitation therapy services are *NOT* covered for FESP recipients.

Respiratory Therapy

Respiratory therapy is an AHCCCS covered treatment service, ordered by a primary care provider for recipients or attending physician for Fee-For-Service (FFS) recipients, to restore, maintain or improve respiratory functioning.

Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures, observing and monitoring signs and symptoms, general behavioral and physical response(s) to respiratory treatment and diagnostic testing, including a determination of whether these signs, symptoms, reactions, or response exhibits abnormal characteristics; and implementing appropriate reporting referral, and respiratory care protocols or changes in treatment based on observed abnormalities and pursuant to a prescription by a physician.

AHCCCS covers medically necessary respiratory therapy services for all recipients on both an inpatient and outpatient basis.

Respiratory therapists must bill with code S5180-Home health respiratory therapy, initial evaluation.

Physicians and hospitals may use CPT codes 94010 - 94799.

Refer to AMPM Chapter 310-T for further information.

Residents, Interns, Teaching Physician and Dentist

A hospital may not submit a claim for professional services rendered unsupervised by a resident or intern using the hospital's provider ID, the attending/teaching physician's provider ID, or the chief of staff's provider ID number.

Patient services rendered by the attending/teaching physician solely in the capacity of teaching are excluded from reimbursement.

The attending/teaching physician may submit a claim for professional services if:

1. The attending/teaching physician is present for a key portion of the time the service being billed was performed.

   For deliveries, the attending/teaching physician must be present for the requisite number of prenatal visits and the delivery in order to bill the global OB code.

   If the attending/teaching physician is present only for the delivery, he/she must bill the "delivery only" code. (See obstetrical services, this chapter)

2. For surgery or dangerous/complex procedures, the attending/teaching physician is present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.
3. For inpatient and outpatient evaluation and management services, the attending/teaching physician is present during the key portion of the visit.

Documentation substantiating the above criteria must be available for audit purposes.

All claims are subject to post-payment review and recovery per A.R.S. §36-2903.01 L.

Hospital Outpatient department setting or other ambulatory entity

Consistent with Medicare, AHCCCS permits an exception to the direct supervision rule for certain primary care residency programs. The exception rule allows specific low level E&M codes to be billed by the teaching physician for services rendered by the residents without the presence of the teaching physician. The permitted codes are limited to:

New Recipient	Established Recipient
99201	99211
99202	99212
99203	99213

Additionally, AHCCCS allows for the reimbursement of Preventative Medicine CPT codes for recipients under 21 years of age. All codes should be used with the "GE" modifier to designate the claim as a teaching physician billing exception claim.

For the above primary care exceptions to apply, the residency program must attest in writing that the following conditions are met:

1. Services must be furnished in an outpatient department of a hospital or other ambulatory entity included in determining GME payments to a teaching hospital.
2. Residents furnishing service without the presence of a teaching physician must have completed more than six months (post graduate) of an approved residency program.
3. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability.
4. The recipients seen must be an identifiable group of individuals who consider the setting and residency program to be the continuing course of their health care. The residents must generally follow the same group of recipients through the course of their residency program.
5. The range of services furnished by the residents includes all of the following: acute and chronic care, care coordination, and comprehensive care not limited by organ system or diagnosis.
6. The types of residency programs most likely to quality for the primary care exception rule include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

Note: This is an abbreviated summary. Refer to Medicare Part B News, Issue #192 October 22, 2001, "Supervising Physicians in Teaching Settings" for complete details.

Teaching physicians are instructed to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective 11/22/2002 which describes clarification to "Supervising Physicians in Teaching Settings – Documentation."

Nursing Facility Setting

AHCCCS permits the billing of the following low level E&M nursing facility CPT codes by the teaching physician for services rendered by the residents without the presence of the teaching physician:

New Recipient	Established Recipient
99301	99311

All codes should be used with the "GE" modifier to designate the claim as a teaching physician billing exception claim.

For the nursing facility exception to apply, the residency program must attest in writing that the following conditions are met:

1. Services must be furnished in a nursing facility.
2. Residents furnishing service without the presence of a teaching physician must have completed more than twelve months (post graduate) of an approved residency program.
3. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must be immediate available via telephone.
4. The recipients seen must be an identifiable group of individuals who consider the setting and residency program to be the continuing course of their health care. The residents must generally follow the same group of recipients through the course of their residency program.
5. The range of services furnished by the residents includes all of the following: acute and chronic care, care coordination, and comprehensive care not limited by organ system or diagnosis.
6. The types of residency programs most likely to quality for the primary care exception rule include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

Teaching physicians are instructed to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective 11/22/2002 which describes clarification to “Supervising Physicians in Teaching Settings – Documentation.”

Dental Students/Dental Residents

AHCCCS permits billing for dental services provided by dental students or dental residents when the following conditions are met:

1. Services must be furnished at the dental school clinic or other dental treatment facility identified by the dental school and permitted by the Dental Practice Act.
2. All dental services must be provided under the direct supervision of a teaching dentist certified as either faculty or adjunct faculty by the dental school.
3. The teaching dentist must be an AHCCCS registered provider in order to bill for services.
4. All treatment notes written by the dental students or residents must be counter-signed by a teaching dentist.

Supplies, Materials, Injectable Drugs

AHCCCS does not reimburse providers on a fee-for-service basis for services billed using procedure code 99070 (Supplies and materials, except spectacles, provided by the physician over and above those usually included with the office visit or other services rendered).

Providers must bill the J Codes for injectable drugs and HCPCS codes for durable medical equipment and supplies.

Surgeon billing

Multiple surgical procedures performed on the same recipient on the same day must be billed using modifier 51.

Providers should list the principal procedure on the first line of the CMS 1500 claim form and list the secondary surgeries on subsequent lines with modifier 51.

- The principal procedure is reimbursed at 100 percent of the capped fee or billed charges, whichever is less.
- Each secondary surgical procedure is reimbursed at 50 percent of the capped fee or billed charges, whichever is less.

If a claim is received without modifiers to indicate secondary procedures, the AHCCCS system identifies the first procedure on the claim as the principal procedure.

All other surgical procedure are identified as secondary and priced at 50 percent of the capped fee or billed charges, whichever is less.

Claims with more than four secondary surgical procedures are subject to medical review.

Certain modifiers indicate less than comprehensive surgical care.

54 Surgical care only
55 Post-operative management
56 Pre-operative management

If multiple surgeons participate in a surgery, the appropriate modifier is necessary to ensure proper payment of claims.

80 Assistant surgeon (reimbursed at 20% of the capped fee or billed charges, whichever is less)
62 Two surgeons
66 Surgical team

If multiple providers bill for the same procedure without modifiers, all but the first claim received will be denied as duplicates.

AHCCCS accepts modifier:

22 – Increased procedural services; or
52 - Reduced services.

These modifiers do not impact reimbursement.

Bilateral procedures performed during the same session are identified by using modifier 50 with the CPT code for the second (bilateral) procedure.

When a procedure is repeated, use of the appropriate modifier reduces the likelihood that the claim will be denied as a duplicate:

76	repeat procedure or service by same physician
77	repeat procedure or service by another physician
78	an unplanned return to the operating/procedure room by the same physician following the initial procedure for a related procedure during the postoperative period

Assistant surgeons must bill with modifier 80. Practitioners providing surgical assist services should bill with modifier AS.

When billing multiple surgical procedures, the secondary procedures should be billed with the appropriate surgical assist modifier (80 or AS) and modifier 51.

When billing for Cesarean delivery assist, bill the code for delivery only with the appropriate assist modifier.

Telemedicine

AHCCCS covers medically necessary services provided via telemedicine.

Service delivery via telemedicine can be in one of two modes:

- *Real time* means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and the spoke site.
  - Hub site means the location of the telemedicine consulting provider, which is considered the place of service.
  - Spoke site means the location where the recipient is receiving the telemedicine service.

    Diagnostic, consultation, and treatment services are delivered through interactive audio, video, and/or data communication.
- *Store-and-forward* means transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

The following medical services are covered, both real time and store-and-forward:

Cardiology	Oncology/radiation
Dermatology	Ophthalmology
Endocrinology	Orthopedics
Hematology/oncology	Pain clinic
Home health	Pathology & Radiology
Infectious diseases	Pediatrics and pediatric subspecialties
Neurology	Rheumatology
Obstetrics/gynecology	Surgery follow-up and consultations

Non-emergency transportation to and from the spoke site to receive a medically necessary consultation or treatment is covered for Title XIX recipients only.

Behavioral health services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) recipients.

Covered behavioral health services include (real time only):

- Diagnostic consultation and evaluation
- Psychotropic medication adjustment and monitoring
- Individual and family counseling
- Case management

For real time behavioral health services, the recipient's physician, case manager, behavioral health professional, or tele-presenter may be present with the recipient during the consultation.

Conditions and limitations

At the time of service delivery via real time telemedicine, the recipient's PCP, attending physician, or other medical professional employed by the PCP or attending physician who is familiar with the recipient's condition may be present with the recipient.

Other medical professionals include registered nurses; licensed practical nurses; clinical nurse specialists; registered nurse midwives; registered nurse practitioners; physician assistants; physical, occupational, speech, and respiratory therapists; and a trained tele-presenter familiar with the recipient's medical condition.

All services provided via telemedicine must be reasonable, cost effective and medically necessary for the diagnosis or treatment of a recipient's medical or behavioral health condition.

Services must be billed on a CMS 1500 claim form using the "GT" modifier to designate the service being billed as a telemedicine service.

Services are billed by the consulting provider.

Unlisted or unspecified services

Procedure codes for unspecified or unlisted procedures (identified by CPT codes ending in "99") should only be billed in situations where no other code adequately describes the service performed.

Providers who bill procedure codes for unspecified or unlisted procedures must describe the service rendered and identify the service in the procedure or operative report.

Claims with such procedure codes are subject to Medical Review.

Ventilator management

Providers should not bill AHCCCS for any E/M service when submitting claims for global ventilator management services.

CPT Codes 94002 (Ventilation assist and management, first day); 94003 (Ventilation assist and management, subsequent days) and 94004 (Ventilation assist and management, nursing facility, per day) are global procedure codes.

Claims with an E/M code in addition to a ventilator management code are subject to denial during Medical Review.

REVISION HISTORY

Date	Description of changes	Page(s)
03/30/2016	Updated NCCI associated modifier section with link to CMS for quarterly list updates	3
12/21/2015	Correction to Telemedicine . Conditions and limitations: Remove "must" and replaced with "may" to read "…may be present with the recipient." to conform to AMPM language	39
12/21/2015	Add Revision History to chapter	40